



JOHN N. RHODES, M.D., F.A.A.P.  
 MICHAEL J. MARZULLO, M.D., F.A.A.P.  
 37 Calvert Street  
 Alexandria, Louisiana 71303  
 Phone (318) 443-9634 • Fax (318) 443-9809

**NEW MOM INFORMATION**

Date: \_\_\_\_\_  John Rhodes M.D.  Michael Marzullo M.D.

Infant's Last Name: \_\_\_\_\_ Due Date: \_\_\_\_\_

Will the infant's last name change at birth, if yes, new name: \_\_\_\_\_

Will infant reside in same household with natural parent(s):  mom  dad  both

Obstetrician: \_\_\_\_\_ Hospital: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ (last) \_\_\_\_\_ (first)

Mother's Date of Birth: \_\_\_\_\_

Father's Name: \_\_\_\_\_ (last) \_\_\_\_\_ (first)

Father's Date of Birth: \_\_\_\_\_

Mother's Medical History:

Any special problems with this pregnancy:

\_\_\_\_\_  
 \_\_\_\_\_

Blood type/RH: Mother \_\_\_\_\_ Father: \_\_\_\_\_

(Answer yes or no)

Fever: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_ Rashes: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Infection: \_\_\_\_\_ Bleeding: \_\_\_\_\_

Medication/drugs taken during pregnancy and when: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

X-rays or injury during pregnancy and when: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Cesarean Section Planned?  Yes  NO; Reason: \_\_\_\_\_

Plans for Labor, Delivery, etc. Comment regarding childbirth classes, father's participation in labor and delivery, preferred anesthesia, etc.)

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Plans for feeding:  Breast  Bottle  Undecided

MALE INFANT: Circumcision:  YES  NO  Undecided

Previous Pregnancies: \_\_\_\_\_ including present; \_\_\_\_\_ # of Living children \_\_\_\_\_ Miscarriages

Year of Birth	Sex	Birth Weight	Special Problems	Pt. here/Name
_____	_____	_____	_____	y/n _____
_____	_____	_____	_____	y/n _____
_____	_____	_____	_____	y/n _____
_____	_____	_____	_____	y/n _____

IMMUNIZATIONS: Do you have a problem immunizing your child?  Yes  No

#### ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR INFORMATION RELEASE

1. I hereby assign and authorize payment of Medicaid and other insurance benefits, otherwise payable to me, directly to Rhodes Pediatric Clinic (Dr. Rhodes and Dr. Marzullo) for office or hospital services, which are not paid by me at the time of service.
2. I understand that I am ultimately responsible for payment of any and all charges for treatment received and if the assigned claim is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full.
3. I hereby authorize Rhodes Pediatric Clinic and its providers, to provide treatment for the patient listed above, and to release all information pertaining to office or hospital services rendered to me by said practice, including the diagnosis and treatment rendered to me by previous physicians, hospitals, or other medical facilities/personnel.

Parent/Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_